



**CONFIDENTIAL HEALTH QUESTIONNAIRE**  
**INFORMATION FOR THE SCHOOL HEALTH TEAM ONLY**

**DAY AND FLEXI BOARDING PUPILS**

**To the Parents:**

Please complete and return this questionnaire at least two weeks before your son or daughter enters the school. During the school day the school is responsible, in loco parentis, for the welfare of pupils. Therefore it is essential that the Bootham School Health Centre Team have access to important medical information. If a day or flexi boarder is ill or has an accident, parents are always contacted where possible. Initial treatment is administered by the Health Team, who will liaise with the parents / guardians and / or the family doctor where appropriate. Should your son or daughter, following initial treatment, require additional medical assessments and / or treatment, then you are responsible for facilitating collection, transportation and follow up care of your son / daughter following a request from the Health Team. Only in cases of emergency will pupils be accompanied by a member of the health care support team to access additional medical care. Parents / guardians will be expected to meet and relieve accompanying health care support staff as soon as possible.

**IF YOUR SON/DAUGHTER IS A FLEXI BOARDER, HE/SHE WILL BE EXPECTED TO RETURN HOME UNDER THE CARE OF HIS/HER OWN DOCTOR IF UNWELL WHILST BOARDING.**

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**The admission or retention of a pupil at the School is conditional upon acceptance of the following:-**

**Consent to Treatment**

If a pupil requires special medical treatment, every effort will be made to obtain the prior consent of the parent or guardian or UK guardian, or the pupil, if aged 16 or over. Should this be impossible in the time available, the Headmaster or his deputy, acting **in loco parentis**, is authorised to give consent to such treatment (including anaesthetic or operation) as may be recommended by the School Medical Officer or his deputy.

Immunisation against infectious disease may be required from time to time and individual consent will be sought from parents / guardians.

**Special Medical Needs**

The parents/guardians of all pupils attending the School who have a special medical need such as anaphylaxis, epilepsy or cerebral palsy etc., are required to complete and annually update a Health Care Plan (HCP), copies of which can be downloaded from the School website. The HCP will be shared with relevant school staff to ensure the pupil's individual needs are met.

**Information**

Throughout a pupil's time at the School, the School Medical Officer / School Nurse Manager shall have the right to give to the pupil's parents, guardian, or Headmaster, any confidential information if he / she considers that it is in the pupil's best interest or that it is necessary to do so for the health or protection of other members of the School community.

**CONFIDENTIAL HEALTH QUESTIONNAIRE:**  
**INFORMATION FOR THE BOOTHAM SCHOOL HEALTH TEAM ONLY**

**TO THE PARENTS**

**FULL NAME OF PUPIL:** \_\_\_\_\_  
(Underline first name used)

**NHS No:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_ **Sex: Male / Female**  
(Please delete as applicable)

**Home Address:** \_\_\_\_\_

**Full Tel No (Home)** \_\_\_\_\_

**Full Tel No (Business)** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Name & Address of UK Guardian (for overseas pupils)**

\_\_\_\_\_  
\_\_\_\_\_

**Full Tel No** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**NAME & ADDRESS OF GENERAL PRACTITIONER (GP):** \_\_\_\_\_

\_\_\_\_\_

**Full Tel No (GP):** \_\_\_\_\_

**PLEASE UNDERLINE ANY OF THE FOLLOWING DISEASES WHICH THE PUPIL HAS HAD:**

**CHICKENPOX  
(PERTUSSIS)**

**GERMAN MEASLES (RUBELLA)**

**WHOOPIING COUGH**

**MUMPS**

**MEASLES**

**TROPICAL DISEASE (PLEASE STATE WHICH):** \_\_\_\_\_

Please give details of immunisations against the following diseases:

Immunisations received	Schedule	Dates of all immunisations given (If no date is given we will assume not immunised)
Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Hib (a bacterial infection that can cause severe pneumonia or meningitis in young children) these are given as a combined 5-in-1 single injection	Usually given at 2 months	Date:
Pneumonia	Usually given at 2 months	Date:
5-in-1 (second dose)	Usually given at 3 months	Date:
Meningitis C	Usually given at 3 months	Date:
5-in-1 (third dose)	Usually given at 4 months	Date:
Pneumonia (second dose)	Usually given at 4 months	Date:
Meningitis C (second dose)	Usually given at 4 months	Date:
Meningitis C (third dose)	Usually given at 12 months	Date:
Hib (fourth dose)	Usually given at 12 months	Date:
M.M.R. (Measles, Mumps, Rubella) given as a single jab	Usually given at 13 months	Date:
Pneumonia third dose	Usually given at 13 months	Date:
Diphtheria, tetanus, pertussis and polio pre-school booster	Usually given aged 4-5 yrs	Date:
M.M.R. (Measles, Mumps, Rubella) pre-school booster	Usually given aged 4-5 yrs	Date:
Hepatitis A (usually given as a travel vaccination):		Date:
Typhoid (usually given as a travel vaccination):		Date:
Tetanus Diphtheria/Polio (Td/IPV) booster jab	Usually given aged 13/18 yrs	Date:
<b>TUBERCULOSIS (BCG) (PROOF OF THIS WILL BE REQUIRED FOR PUPILS FROM OVERSEAS)</b>	<b>Date:</b>	
<b>PLEASE DETAIL ANY OTHER VACCINATION RECEIVED NOT ALREADY SPECIFIED, E.G. YELLOW FEVER, RABIES, HEP B</b>	<b>PLEASE LIST AND GIVE DATE OF ADMINISTRATION:</b>	

Human papillomavirus (HPV), girls only, three jabs given within eight months		
HPV (first dose)	Usually given aged 12-13 yrs	Date:
HPV (second dose)	Usually given aged 12-13 yrs	Date:
HPV (third dose)	Usually given aged 12-13 yrs	Date:

Please give details of any known exposure to active pulmonary tuberculosis.

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Does the pupil have a colour vision deficiency? **YES/NO**

If yes please give full details:

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Does the pupil have any hearing problems? **YES/NO**

If yes please give full details:

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**Has treatment been required for any of the following conditions?**

	YES	NO		YES	NO
Asthma (If yes, give full details)			Deafness (If yes, give full details)		
Eczema (If yes, give full details)			Frequent Sore Throat (If yes, give full details)		
Hay Fever (If yes, give full details)			Psychological Problems (If yes, give full details)		
Bone or Joint Disease (If yes, give full details)			Epilepsy, seizures, or Convulsions (If yes, give full details)		
Diabetes (If yes, give full details)			Anaphylaxis (If yes, give full details)		

RE THE ABOVE TABLE, IF YOU HAVE RESPONDED YES TO ANY OF THE ABOVE CONDITIONS PLEASE

**GIVE FULL DETAILS OF THE CONDITION AND TREATMENT RECEIVED:** \_\_\_\_\_

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Please give full details of any other illness, operation, hospital investigation, injury or congenital condition / disability:

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Please give details of any known allergy, including sensitivity to drugs, its severity and any prescribed medication if applicable:

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Please give details of any history of asthma, eczema, hay fever, its severity and any prescribed medication if applicable:

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Is there any serious / significant difficulty in learning to read or write? \_\_\_\_\_

Is there any history of physical or mental illness in the family which might have a bearing on health?

(e.g. early cardiac problems) \_\_\_\_\_

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Is there a history of fainting episodes?

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Is there any concern regarding the pupil's physical and/or mental/emotional health which you feel the School Doctor / Bootham School Health Team should be aware of, or which you would like to discuss?

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**IS THE PUPIL AT PRESENT UNDER ANY FORM OF MEDICAL/PSYCHOLOGICAL TREATMENT?**

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TO ENSURE THE PUPIL RECEIVES THE APPROPRIATE CARE THE BOOTHAM SCHOOL HEALTH CENTRE TEAM NEEDS A WRITTEN CONSENT TO BE IN PLACE FOR THE FOLLOWING **THREE** ELEMENTS:

1. **CONSENT TO TREATMENT:** If a pupil requires medical treatment, every effort will be made to obtain the prior consent of the parent/guardian/UK guardian, or of the pupil, if aged 16 or over. Should this be impossible in the time available, the Head Teacher or his deputy, acting in loco parentis, is authorised to give consent to such treatment (including anaesthesia or a surgical operation/procedure) as may be recommended by the School Medical Officer or his deputy.

\*I consent / do not consent for the Head Teacher/Deputy Head to authorise for my son / daughter to receive necessary medical care, including anaesthesia or a surgical operation/procedure, if the school is unable to contact me to gain consent in an emergency.

**\* PLEASE DELETE AS APPROPRIATE re consent for treatment**

**Please note that the admission or retention of a pupil at the School is conditional upon acceptance of the above.**

**Please continue overleaf:**

2. **INFORMATION SHARING:** The information given in this health questionnaire is regarded as confidential. However, there are certain medical conditions which may affect the day-to-day living of the pupil and relevant members of staff will need to be aware of this. For example, these may include epilepsy, diabetes, anaphylaxis, allergies and asthma. (This is not a definitive list.)

Additionally, it is important that the teaching staff are informed about a pupil with a colour vision deficiency problem, as in examinations for subjects such as geography, map coloured coding is used and special arrangements need to be put in place so as not to disadvantage such pupils.

**\* I consent / do not consent** for information to be shared.

**\* PLEASE DELETE AS APPROPRIATE re information sharing**

3. **ADMINISTRATION OF MEDICATION:** Our School Doctor has approved a limited list of non-prescription medicines to be given by the health centre staff. These are given for minor ailments such as headache, stomach-ache and nasal congestion, according to agreed protocols.

**\* I consent / do not consent** for the pupil to receive non-prescription medicines from trained/authorised school staff according to an agreed protocol.

**\* PLEASE DELETE AS APPROPRIATE re the administration of non-prescribed medicines.**

**PLEASE DELETE AS APPROPRIATE TO GIVE / DECLINE CONSENT RE THE ABOVE, THEN PLEASE SIGN BELOW TO GIVE WRITTEN PERMISSION FOR THE ELEMENTS YOU HAVE CONSENTED TO:**

**SIGNATURE OF PARENT OR GUARDIAN** \_\_\_\_\_

**DATE:** \_\_\_\_\_

The above signature authorises consent for the elements above which the parent / guardian has indicated they consent to by deleting as appropriate.

**BEFORE YOU RETURN THIS FORM TO THE SCHOOL PLEASE ENSURE THAT YOU HAVE:**

- **COMPLETED ALL QUESTIONS**
- **INDICATED WHETHER OR NOT YOU CONSENT TO THE THREE CARE ELEMENTS DETAILED ABOVE**
- **SIGNED THE DOCUMENT TO AUTHORISE THE CONSENTS YOU HAVE GIVEN VIA DELETING APPROPRIATELY**

**IF THERE IS A CHANGE IN THE MEDICAL CIRCUMSTANCES OF THIS PUPIL DURING THE TIME HE/SHE IS AT BOOTHAM SCHOOL WOULD YOU KINDLY INFORM THE BOOTHAM SCHOOL HEALTH CENTRE TEAM.**